



Designation of Beneficiary
Federal Employees' Group Life Insurance (FEGLI) Program
(DO NOT erase or cross-out. Use a new form.)

Form Approved
OMB No. 3206-0136

Important:
Read instructions on the
Back of Part 2 before completing this form.

A. Information About the Insured (not the Assignee, if there is one) (type or print)

Name of Insured (Last, first, middle) FEDERICO, ROBERT GEORGE	Date of birth of Insured (mm/dd/yyyy) 11/09/1947	Social Security Number of Insured 069-38-8963
The Insured is: Place an "X" in the appropriate box. <input checked="" type="checkbox"/> an employee <input type="checkbox"/> a retiree <input type="checkbox"/> a compensationner	If the Insured is retired or receiving Federal Employees' Compensation, give CSA, CSI, or OWCP claim number:	

Department or agency where the Insured works (If retired, last department or agency where the Insured worked):

Department or agency GSA-PBS	Bureau or division NCR-TRIANGLE	Location (city, state, and ZIP code) WASHINGTON, DC 20407
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B. Information About the Beneficiary or Beneficiaries (See Back of Part 1 for examples) (type or print)

First name, middle initial, and last name of each beneficiary	Social Security Number	Address (Including ZIP code)	Relationship	Percent (or fraction) designated
DONNA ROSA	138-44-6970	9923 CAPPERTON DRIVE OAKTON, VA 22124	FIANCEE	100 %

Total (Must equal 100% or 1.0) (Do not use dollar amounts) _____
(Do not put a Total if you designated types of insurance. See example 4 on Back of Part 1.)

C. Statement of Insured or Assignee (type or print)

Your name and address (Including ZIP code) ROBERT G. FEDERICO P.O. Box 1645 SPRINGFIELD, VA 22151	Please check one: I am: <input checked="" type="checkbox"/> the Insured <input type="checkbox"/> an Assignee See Back of Part 2 for definitions	Please check all three: <input checked="" type="checkbox"/> I have not assigned the insurance. <input checked="" type="checkbox"/> Two people who witnessed my signature signed below. <input checked="" type="checkbox"/> I did not name either witness as a beneficiary.
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I understand that if there is a valid assignment on file, only the assignee has the right to designate a beneficiary. If a valid assignment is not on file, but there is a valid court order on file with the agency or the U.S. Office of Personnel Management, as appropriate, any designation I complete for the same benefits is not valid.

I understand that if this Designation is valid, it will stay in effect unless it is canceled. (See "When Is A Designation Canceled?" on the Back of Part 2).

I understand that if this Designation is invalid for any reason, the Office of Federal Employees' Group Life Insurance will pay benefits according to the next most recent valid designation. If there isn't one, it will pay according to the order listed on the Back of Part 2.

I am canceling any and all previous Designations of Beneficiary under the Federal Employees' Group Life Insurance Program and am now designating the beneficiary(ies) named above.

Signature of Insured/Assignee (Only the Insured/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.) This form is not valid unless the Insured/Assignee signs in this box.

Date (mm/dd/yyyy)

Robert G. Federico

6/20/02

D. Witnesses To Signature (A witness is not eligible to receive a payment as a beneficiary.)

Signature of witness Matthew Pute	Address (Including ZIP code) 2803 Farris Lane Bowie MD 20708
Signature of witness	Address (Including ZIP code)

E. For Agency Use Only

Receiving agency GSA	Date of receipt (mm/dd/yyyy) 6/24/02	Signature of authorized agency official Manuel Llanusa	Title HRA
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Part 1 - Original



Designation of Beneficiary

Federal Employees' Retirement System

Form Approved
OMB No. 3206-0173

RECEIVED
GSA-KC-CPC

Important:
Read all instructions before
filling in this form

2006 JUL 12 AM 10:54

A. Identification

Name (Last, first, middle) Federico, Robert George		Date of birth (Month, day, year) 11/04/1947	Social Security Number 069-38-8963
Place an "X" in the appropriate box:	<input checked="" type="checkbox"/> An employee	<input type="checkbox"/> Retired or an applicant for retirement	<input type="checkbox"/> Former employee eligible for retirement in the future
If you are retired give your claim number			
Department or agency in which presently employed (or former department or agency):			
Department or agency GSA-PBS	Bureau PBS-NCR	Division NCR-WPZ (Triangle Services)	Location (City, state and ZIP code) Washington, DC 20407

I, the individual identified above, designate the beneficiary or beneficiaries named below to receive any lump-sum benefit which may become payable under the Federal Employees' Retirement System (FERS) after my death. I understand that this designation of beneficiary is also for any lump-sum benefit which may become payable under the Civil Service Retirement System (CSRS) after my death. I understand that this designation of beneficiary cancels any previous FERS or CSRS designation of beneficiary, and that it remains in effect until I cancel it in writing or I receive payment of my employee deductions for FERS (and CSRS, if applicable).

I direct, unless otherwise indicated below, that if more than one beneficiary is named, the share of any beneficiary who may predecease me or who may be disqualified for any other reason, shall be distributed equally among the stated beneficiaries, or entirely to the survivor. If none of the beneficiaries are alive and eligible to receive payment when a lump-sum payment becomes payable, this designation is void, and payment will be made according to the order of precedence set by law.

B. Information Concerning The Beneficiaries (See Examples of Designations):

First name, middle initial, and last name of each beneficiary	Address (Including ZIP code) of each beneficiary	Relationship	Share to be paid to each beneficiary
Donna Rosa Federico	9158 Stonegarden Drive, Lorton, VA 22079	Spouse	95
Robert S. Federico	9158 Stonegarden Drive, Lorton, VA 22079	Son	5
Date of designation (Month, day, year) 07/07/2006	Your signature <i>Robert Federico</i>		Total = 100%

C. Witnesses (A witness is not eligible to receive payment as a beneficiary):

We, the undersigned, certify that this statement was signed in our presence.

Signature of witness <i>R. White</i>	Number and street 2005 Ridgecrest Ct SE.	City, state and ZIP code Wash D.C. 20020
Signature of witness <i>Brenda Taylor</i>	Number and street 381-TH St SW	City, state and ZIP code Wash, DC 20407

Receiving agency certification

I have reviewed this designation and certify that the designated shares total 100% and that no witnesses are designated as beneficiaries.

Date received 7/12/06	Signature <i>[Signature]</i>	Date 7/12/06
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Type or print your return address to insure return of

Robert G. Federico
P.O. Box 1318
Lorton, VA 22199

See Back of Employee Copy For Instructions
On Where To File This Form.
(Retain until employee leaves Federal
service, and then send to OPM)

DESIGNATION OF BENEFICIARY
UNPAID COMPENSATION OF
DECEASED CIVILIAN EMPLOYEE

IMPORTANT
Read instructions
on back of duplicate
before filling in this form

INFORMATION CONCERNING THE EMPLOYEE:

NAME	(Last)	(First)	(Middle)	DATE OF BIRTH (month, day, year)
	FEDERICO	ROBERT	GEORGE	11/04/1947
				Social Security Number
				069-38-8963

DEPARTMENT OR AGENCY IN WHICH EMPLOYED

(Department or agency)	(Bureau)	(Division)
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I, the employee named above, canceling any and all previous Designations of Beneficiary heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any UNPAID COMPENSATION due and payable after my death. I understand that this Designation of Beneficiary relates solely to money due as defined in 5 U.S.C. 5581, 5582, 5583, and in no way will affect the disposition of any benefit which may become payable under the Retirement or Group Life Insurance Acts applicable to my Government service. I further understand that this Designation of Beneficiary will remain in full force and effect until (1) expressly changed or revoked by me in writing, (2) I transfer to another agency, or (3) I am reemployed by the same or another department or agency of the Government.

INFORMATION CONCERNING THE BENEFICIARY OR BENEFICIARIES:

Type or print first name, middle initial, and last name of each beneficiary	Type or print address (including ZIP Code) of each beneficiary	Relationship	Share to be paid to each beneficiary
ELIZABETH SHARPE	14471 BRENTWOOD CT WOODBRIDGE, VA 22193	DAU	50%
JOANNE FEDERICO	14471 BRENTWOOD CT. WOODBRIDGE, VA 22193	DAU	50%

I hereby direct, unless otherwise indicated above, that, if more than one beneficiary is named, the share for any deceased beneficiary who may predecease me shall be distributed equally among the surviving beneficiaries, or entirely to the survivor. I understand that this Designation of Beneficiary shall be void if none of the designated beneficiaries is living at the time of my death.

I hereby specifically reserve the right to cancel or change any designation of beneficiary, at any time, in the manner and form prescribed by the Comptroller General of the United States, and without knowledge or consent of the beneficiary.

06/17/02
(Date of execution—month, day, year)

Robert J. Federico
(Signature of employee)

WITNESSES TO SIGNATURE:

Nicole Snowden
(Signature of witness)

14th and D Streets, S.W. Washington, DC 20407
(Number and street) (City, State, and ZIP Code)

Bettie V. Smith
(Signature of witness)

14th and D Streets, S.W. Washington, DC 20407
(Number and street) (City, State, and ZIP Code)

PRINT OR TYPE NAME AND ADDRESS (INCLUDING ZIP CODE) OF EMPLOYEE

THIS SPACE RESERVED FOR RECEIVING DATA
OF EMPLOYING AGENCY

(Indicate date and by whom received)

DELIVER BOTH COPIES TO THE PROPER OFFICER OF YOUR AGENCY—DUPLICATE WILL BE NOTED AND RETURNED

